In the Matter of	:	
	:	Date Issued: September 6, 2000
WILLIAM D. LAWSON	:	Case No. 1999-BLA-0344
Claimant	:	
	:	
v.	:	
	:	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS	:	
Party in Interest	:	

DECISION AND ORDER

This proceeding arises from a petition for modification of the denial of a claim for benefits filed pursuant to the Black Lung Benefits Act, as amended, 30 U.S.C. § 901, *et seq.*, (the "Act"), and the regulations promulgated thereunder, 20 C.F.R. Parts 718 and 725. Benefits are awarded under the Act to coal miners who are totally disabled due to pneumoconiosis, a dust disease of the lungs arising from coal mine employment, and commonly known as black lung disease. 20 C.F.R. § 718.201.

Procedural History

The original claim for benefits was filed on July 2, 1985. (DX 2). It is a duplicate claim to one filed on July 11, 1978 which was denied and closed. (DX 1). The duplicate claim was denied by the District Director on December 23, 1985. (DX 33). The case was then forwarded to the Office of Administrative Law Judges and was heard by Judge Glennon, who denied benefits on August 7, 1991. In his opinion, Judge Glennon found that Claimant had established 10 years of coal mine employment, and that Claimant's x-ray evidence established the existence of pneumoconiosis. Pursuant to the regulations at 20 C.F.R. §§ 718.202(a)(1) and 718.203(b), Judge Glennon afforded Claimant the presumption that his pneumoconiosis arose out of his coal mine employment. However, benefits were denied because Judge Glennon ruled that Claimant failed to establish total disability. (DX 50). Judge Glennon's decision was appealed to the Benefits Review Board and subsequently affirmed, whereupon, Claimant appealed to the Fourth Circuit. (DX 55).

The Fourth Circuit remanded the case for reconsideration of whether the medical evidence established total disability and whether or not pneumoconiosis played a role in any such disability. (DX 57). On remand, Judge Bonfanti denied benefits on June 26, 1995. In his decision, Judge Bonfanti stated that the medical evidence established total disability, but Claimant's disabling condition was due to heart disease. (DX 64). This ruling was appealed to the Benefits Review Board, but before they could issue a decision, Claimant filed a motion for modification based upon a CT scan performed by Dr. Siner on March 6, 1991 which Claimant alleged established the presence of complicated pneumoconiosis. (DX 74). The case was then remanded to the District Director in order to determine whether modification should be granted. (DX 75). The District Director found no change of condition or mistake in fact that would merit modification and denied Claimant's request on October 21, 1986. (DX 81). Claimant appealed this determination, and an Informal Conference was scheduled for March 13, 1997. In the Memorandum of Conference dated March 20, 1997, the District Director stated he considered Claimant's Request for Modification and considered his entitlement to benefits *de novo*. He found that Claimant failed to establish any of the elements to entitlement, and he found that Claimant failed to establish a material change in conditions. (DX 83).

Claimant appealed the denial of benefits on April 7, 1997, and his case was assigned to the Judge Wood for a formal hearing. (DX 84, 85). At issue before the Office of Administrative Law Judge was whether Claimant established any of the elements of his claim and whether Claimant established a material change in conditions or a mistake made in the determination of any fact. (DX 85). The hearing was held on September 18, 1997. On July 30, 1998, Judge Wood issued an Order of Remand in which the case was remanded to the District Director's office for a new medical examination to be conducted because the most recent exam had been conducted in 1991. She additionally noted that the decision to deny benefits on modification contained in the Memorandum of Conference was based upon consideration of only part of the record. (DX 97).

On October 2, 1998, an Order Clarifying Remand was issued in which Judge Wood excused Claimant from undergoing a pulmonary function test due to his poor health, but ordered him to undergo a physical examination, chest x-rays, and blood gas studies. After Claimant's September 15, 1998 exam, x-rays, and blood gas study, the District Director issued a decision denying the claim. The District Director stated that based on all the evidence available in the claim file, Claimant failed to establish "disease, causality, disability or a change in condition." The claim was then referred back to the Office of Administrative Law Judges. (DX 106).
A hearing before Judge Wood was scheduled for April 28, 1999. However, an Order for Continuance was granted on April 14, 1999, and the case was reassigned to me with a hearing scheduled for June 8, 2000. Pursuant to a letter dated May 23, 2000, the parties agreed to a decision on the record.

Issues

The contested issues are as follows: 1) length of employment; 2) whether the miner's pneumoconiosis arose out of coal mine employment; 3) whether the miner is totally disabled; 4)

whether the miner's disability is due to pneumoconiosis; 5) whether the evidence demonstrates a material change in conditions pursuant to 20 C.F.R. § 725.309 (c)(d); and 6) whether the evidence establishes a change in conditions and/or that a mistake was made in the determination of any fact in the prior denial pursuant to 20 C.F.R. § 725.310.

Medical Evidence

X-Rays and CT Scans

DATE	PHYSICIAN	INTERPRETATION
9-15-98	Dr. Cole, B, Board Cert.	Negative for pneumoconiosis, Cardiac enlargement
9-15-98	Dr. Forehand, B	Negative for pneumoconiosis, Enlarged cardiac silhouette
3-29-93	Dr. Patel	mild hyper-inflated lungs, moderate cardiac enlargement
1-20-93	Dr. Emery	Mild pulmonary hyperinflation is noted and some increased interstitial lung markings, but no acute change. Well rounded nodule overlying heart shadow on lateral view
3-18-92	Dr. Patel	Possibility of fluid in right pleural space can't be excluded
12-30-91	Dr. Emery	Approximately 8 mm non-calcified rounded nodule is noted overlying lingula on lateral view adjacent to aortic valve shadow
7-1-91	Dr. Emery	Cardiomegaly, tortuous aorta as well as some chronically increased interstitial pulmonary infiltrates in lower lung fields. Poorly defined nodular density seen overlying the heart on lateral view appears unchanged from previous films

3-30-91	Dr. Lepsch, BCR	Parenchymal disease in both lung bases consistent with atelectasis or consolidation
3-14-91	Dr. Durnic, BCR	1/1 Positive for CWP
3-14-91	Dr. Sargent, BCR, B	1/0 Positive for CWP
3-14-91	Dr. Fowler	No active disease
3-6-91	Dr. Navani, BCR, B	No evidence of coal workers' pneumoconiosis seen, small nodular densities in category p: 0/1. **CT Scan**
3-6-91	Dr. Siner, BCR	Grossly non-calcified 1 cm right middle lobe pulmonary nodule representing either a non or partially calcified granuloma or an early neoplasm. This density is not definitely seen on the PA film. Pulmonary interstitial markings are mildly diffusely prominent, likely representing a chronic abnormality- **CT Scan**
2-25-91	Dr. Emery	Tortuous aorta and hilar granulomata and mild cardiomegaly. Some increased chronic interstitial lung markings and reticulonodular parenchymal changes and no acute infiltrates or pleural abnormalities are noted in comparison to other films
2-8-91	Dr. Siner, BCR	1 cm well circumscribed nodular density, nodular density. Could represent a non-calcified granuloma, No other evidence of active pulmonary disease- **CT Scan**
1-9-91	Dr. Aycoth, B	1/0-scattered rounded opacities measuring up to 1.5 mm
1-9-91	Dr. Cappiello, B	1/1- 1 cm diameter nodule in right

		middle lobe without apparent calcification, no large opacities identified, scattered small parenchymal opacities, changes of COPD
6-19-89	Dr. Patel	Emphysema and findings indicative of chronic interstitial disease noted
7-18-88	Dr. Patel	Moderate emphysematous changes, mild cardiac enlargement
4-19-88	Dr. Durnic, BCR	1/0, no acute pulmonary disease
4-19-88	Dr. Pitman, BCR, B	1/1
8-22-85	Dr. Gaziano, B	0/1 Negative for CWP
8-22-85	Dr. Milner, BCR	0/1 negative for CWP
1-10-80	Dr. Erylimaz, BCR, B	A few p type opacities in each lung with a profusion of 1:0, slight pulmonary emphysema, minimal pneumoconiosis
9-20-73	Dr. Rosenstein, BCR, B	Negative
9-20-73	Dr. Stilik BCR, B	Negative
6-22-73	Dr. Brittingham, B, BCR	UICC category 1/1 S, changes consistent with early pneumoconiosis
6-5-73	Dr. Cunningham, BCR, B	Negative
6-5-73	Erylimaz, BCR, B	1/0
6-5-73	Dr. Sargent, BCR, B	Negative

Under §§ 718.202(a)(1), a chest x-ray conducted and classified in accordance with §§ 718.102, may form the basis for a finding of the existence of pneumoconiosis. In general, where two or more x-ray reports are in conflict, consideration shall be given to the radiological qualifications of the physicians interpreting such x-rays. Although the regulations provide no guidance for the evaluation of CT or CAT scans, Section 718.304(c) provides for new methods of diagnosis, and allows the consideration of any acceptable medical means of diagnosis. See 20 C.F.R. §§718.304(c). Therefore, when initially weighing the evidence in each category pursuant to Section 718.304, CT scans are not considered x-rays but must be evaluated pursuant to subsection (c) together with any evidence or

testimony which bears on the reliability and utility of CT scans and any other evidence not applicable to subsections (a) and (b). *Melnick v. Consolidation Coal Co.*, 16 BLR 1-31 (1991)(*en banc*).

Pulmonary Function Studies

DATE	**RESULTS**		
3-14-91	FVC 3.37	FEV1 2.40	MVV 93
After bronchodilator	3.83	2.92	124
4-19-88	FVC 3.09	FEV1 2.53	MVV 77
8-22-85	FVC 3.91	FEV1 2.97	MVV 107
1-10-80	FVC 2.85	FEV1 2.52	MVV 92
9-20-73	FVC 4.0	FEV1 3.05	MVV 142
5-9-73	FVC 4.79	FEV1 3.81	MVV 149

* None of the pulmonary function tests produced qualifying results. Total disability is not established under § 718. 204 (c) (1).

Blood Gas Studies

DATE	**RESULTS**
9-15-98	PCO2- 38; PO2- 70 PCO2- 70; PO2- 76 with exercise administered (non-qualifying)
3-14-91	PCO2- 32.5; PO2- 71.8 PCO2- 34; PO2- 75 with exercise (non-qualifying)
5-2-88	PCO2- 36; PO2; 74 (non-qualifying)
8-22-85	PCO2- 36.3; PO2- 66.4 Exercise tests contradicted (non-qualifying)
1-10-80	PCO2- 38; PO2- 68 PCO2- 32; PO2- 85 with exercise (non-qualifying)

* Total disability is not established under § 718.204 (c) (2)

Hospital Records and Medical Reports

DATE	PHYSICIAN	IMPRESSION
4-15-97	Dr. Patel	Diagnosed pneumoconiosis, total disability, pulmonary disease arising from coal mine employment, 50% of disability from CWP-above finding based upon x-ray interpretation
12-30-91	Dr. Emery	Left lower lobe nodule-probably represents benign granuloma
7-1-91	Dr. Emery	Incidental finding of solitary nodule probably represents a benign granuloma
5-15-91	Dr. Spagnolo	Reviewed essentially normal pulmonary function studies and arterial blood gas studies in concluding there was no significant pulmonary impairment from underlying pulmonary problem. Finds evidence pneumoconiosis questionable-but states even if accepted, there is no evidence of resulting impairment; attributes category 1 changes found on several x-rays post dating 1988 to Claimant's chronic congestive failure. Shortness of breath due heart disease not underlying pulmonary disease
3-25-91- 4-3-91	Dr. Sewell	Solitary pulmonary nodule-right middle lob, was experiencing chest pain and shortness of breath with moderate activity, had aortic valve replacement
4-12-91	Forehand	Supplement to 3-15-91 report, impairment largely reversible with inhaled bronchidilators, etiology of impairment was suggested to possibly arise from occupational dust- primarily brick- was not definitive.

3-15-91	Forehand	Noted 7 year history of shortness of breath on exertion, wheezing and productive cough, chest pains, diagnosed with partially reversible COPD and valvular heart disease, not evidence of extensive pneumoconiosis
3-6-91	Dr. Bulle	Letter stating Claimant was under his care for congestive heart failure and did not feel competent to comment of whether he has pneumoconiosis
2-25-91	Dr. Emery	Complaints of frequent wheezing, cough productive of yellow sputum, dyspnea on exertion, 2 pillow orthopnea
2-21-91	Dr. Bulle	Congestive heart failure, aortic insufficiency, mitral insufficiency, COPD, lung nodule (1 cm, left upper lobe)-etiology uncertain, history of coal workers' pneumoconiosis
2-8-91	Drs. Bulle/Wagner	Aortic deficiency
1-16-91	Dr. Patel	CWP, totally disabled due to pneumoconiosis
5-5-88- 7-18-88	Dr. Patel	Progress notes, COPD, CWP
4-20-88	Dr. Abernathy	No CWP, shortness of breath due to myocardial disease, evidence of cardiac insufficiency-noted wheezing and shortness of breath with productive cough, chest pains, electrocardiogram revealed left ventricular hypertrophy
8-22-85	Dr. Taylor	Wheezing and productive cough, chest pains, limited physical activities, diagnosed pneumoconiosis as a result of dust exposure from coal mine

		employment
1-10-80	Dr. Peralta, DOL Examiner	Complaints of wheezing and cough for 15 years, chest pains for eight years, diagnosed with hypertension and chest pains upon exertion, could not supply definitive answer as to whether condition related to coal dust exposure.
9-20-73	Dr. Odom	Noted Claimant's exposure to rock, sand and coal dust and his shortness of breath with exertion for five years and productive cough for eight years, found opacities on x-ray rating 1/1 and declared Claimant disabled for coal mine work.

Dr. Forehand, a specialist in pediatrics, allergies, and immunology prepared a recent medical report following his September 15, 1998 examination of Claimant. (DX 102). In it, he noted Claimant's 10 years of coal mine employment at Jewell Ridge Co. as a coal loader. Dr. Forehand discussed Claimant's medical and smoking histories, symptoms, and examination findings and evaluated Claimant's x-ray and pulmonary blood gas data. Claimant had a smoking history consisting of smoking two packs a day from 1940 until1950, when he quit smoking all together. Claimant's medical history includes heart disease, high blood pressure, bronchial asthma, arthritis, frequent colds, and attacks of wheezing.

Regarding Claimant's symptoms, Dr. Forehand recorded complaints of daily yellow phlegm, constant wheezing, dyspnea, cough, chest pain, and orthopnea requiring two pillows. Dr. Forehand also noted shortness of breath when Claimant bent over or taking a breath. Dr. Forehand interpreted the x-ray performed on September, 15, 1998 as negative for CWP. He evaluated a vent study performed on March 14, 1991 as indicating a reversible obstructive ventilatory pattern. The blood gas study performed on September 15, 1998, in his opinion, yielded no indication of metabolic disturbance and no indication of hypoxemia at rest or with exercise. An EKG was also performed on September 15, 1998, and Dr. Forehand read it as demonstrating no acute changes.

Dr. Forehand diagnosed cardiovascular disease, hypertension, and valvular heart disease with mitral and aortic insufficiency with no evidence of simple or complicated pneumoconiosis. Based upon his evaluation, he concluded that Claimant was totally and permanently disabled and ruled heart disease as the sole factor contributing to disability. Furthermore, he stated that there was no evidence of a disabling respiratory impairment or condition arising out of coal mine employment.

Modification

Section 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 922, as incorporated into the Black Lung Benefits Act by 30 U.S.C. § 932(a) and as implemented by 20 C.F.R. §725.310, provides that upon a miner's own initiative, or upon the request of any party on the grounds of a change in condition or because of a mistake in a determination of fact, the fact finder may, at any time prior to one year after the date of last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits. § 725.310(a). The Fourth Circuit does not require that modification requests specify any factual error or change in conditions. Jessee v. Director, OWCP, 5 F.3d 723 (4th Cir. 1993). All that is required is that Claimant allege that the ultimate fact, total disability from pneumoconiosis arising from coal mine employment, was wrongly decided. Id. Upon receiving such a request for modification, all of the evidence is reviewed to determine whether there has been a mistake of fact or a change in conditions. Id.

Duplicate Claim

§§ 725.309 applies only where a claimant has filed a new claim more than one year after the final denial of a prior claim. A claim which is filed within one year is treated as a request for modification and is subject to the provisions of 20 C.F.R. §§ 725.310. Duplicate claims must be denied on the same grounds as the previously denied claim unless the claimant can demonstrate a "material change in conditions." In this case, Claimant is seeking modification of a prior decision denying benefits in a duplicate claim. In *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995), *aff'd*., 86 F.3d 1358 (4th Cir. 1996)(*en banc*), the Fourth Circuit rejected the Board's standard for establishing a "material change in conditions" in a subsequent claim as it was articulated in *Spese*. The court determined that "[t]he purpose of section 725.309(d) is not to allow a claimant to revisit an earlier denial of benefits, but rather only to show that his condition has materially changed since the earlier denial." As such, the court concluded that *Spese* "is an impermissible reading of section 725.309(d)." The court concluded that it would apply the standard set forth by the Sixth Circuit's position in *Sharondale* to state that the judge must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements previously adjudicated against him. The Fourth Circuit declined, however, to adopt the Sixth Circuit's additional requirement that the judge examine the evidence underlying the prior denial to determine whether it "differ[s] qualitatively" from that which is newly submitted.

Discussion

Existence of Pneumoconiosis

20 C.F.R. 718.202 provides that in a living miner's claim the presence of pneumoconiosis may

be established by radiographic evidence, a biopsy, or a reasoned medical opinion. There is no biopsy evidence in this case, but there are a number of x-rays in the record, in addition to three readings of CT scans. It should also be noted that the Director conceded that the existence of simple pneumoconiosis was established by x-ray evidence. (DX 96).

20 C.F.R. 718.302 allows for the rebuttable presumption that a Claimant's pneumoconiosis arose out of his coal mine employment if it is established that Claimant had been employed in the coal mines for 10 or more years. In the present case, the Director disputes the length of employment of fifteen years, as asserted by Claimant. (DX 108). However, in the most recent correspondence dated May 23, 2000, the Position Statement issued by Claimant asserted only 10 years of coal mine employment. Additionally, the Director has previously conceded that Claimant successfully established 10 years of coal mine employment, entitling him to the rebuttable presumption regarding causation. (DX 96). Accordingly, I find no mistake in either Judge Glennon's or Judge Bonfanti's finding 10 years of coal mine employment.

The finding of simple pneumoconiosis by Judge Glennon has been affirmed by the BRB, the Fourth Circuit, and Judge Bonfanti on remand. This, in addition to the Director's concession of the existence of simple pneumoconiosis, leads me to conclude that Claimant is entitled to the rebuttable presumption that his established simple pneumoconiosis arose out of his coal mine employment. Accordingly, the issues left for resolution are whether Claimant is suffering from a totally disabling pulmonary impairment, and if so, is said impairment caused by coal dust exposure.

Total Disability Due to Pneumoconiosis

In order for a Claimant to be found eligible for benefits under the Act, it must be determined that the miner is totally disabled due to pneumoconiosis. Judge Bonfanti ruled that while Claimant successfully established total disability, the weight of the evidence did not support the conclusion that pneumoconiosis contributed to his disability. The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" to the miner's disability. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 94th Cir. 19900; *Robinson v. Pickands Mather & Co.*, 914 F,2d 35, 38 (4th Cir. 1990). Total disability is defined by the Act as an inability to perform regular coal mine work or comparable and gainful work § 718.204 (b). A finding of total disability can be established by the following methods: 1) pulmonary function studies which yield qualifying results; 2) arterial blood gas studies which yield qualifying results; 3) medical evidence establishing pneumoconiosis and cor pulmonale with right sided congestive heart failure; or 4) reasoned medical opinions based upon medically acceptable clinical and
laboratory diagnostic techniques which conclude that a claimant suffers from a disabling respiratory or pulmonary condition.

Additionally, total disability due to pneumoconiosis can be established if the miner is entitled to the irrebuttable presumption of total disability due to pneumoconiosis pursuant to § 718.304. Section 718.304 provides that there is an irrebuttable presumption that a miner is totally disabled due to

pneumoconiosis if the miner is suffering from a chronic dust disease of the lung which by x-ray yields one or more large opacities greater than 1 cm in diameter and would be classified in Category A, B, or C in the ILO-U/C classification, or which by biopsy yields massive lesions in the lung, or is otherwise diagnosed by acceptable medical procedures to be a condition which could reasonably be expected to yield the same results. The determination of whether the miner has complicated pneumoconiosis is a finding of fact, and the Judge must consider and weigh all relevant evidence. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985). The presumption is not invoked by a single piece of or category of evidence being positive for pneumoconiosis, but rather, all relevant evidence bearing on the existence of complicated pneumoconiosis must be weighed. *Lester v. Director, OWCP*, 993 F.2d 1143, 1146 (4th Cir. 1993).

The Fourth Circuit recently issued a decision which expounded upon the appropriate method for weighing medical evidence when making a determination as to whether a claimant is entitled to the irrebuttable presumption created by Section 921(c) (3) of the Act and implemented in § 718.205 of the corresponding regulations. *Eastern Associated Coal Corp. v. Director, OWCP*, ___ F.3d ___, 2000 WL 961592 (4th Cir. 2000). The Court stated that "[W]hile 30 U.S.C. § 921 (c)(3) sets, forth, in clauses (A), (B), and (C), three different ways to establish the existence of statutory complicated pneumoconiosis for the purpose of invoking the irrebuttable presumption, these clauses are intended to describe a single, objective condition." *Id.* at 3. In other words, the three prongs of the statute are written in the disjunctive, allowing for the possibility of a finding of complicated pneumoconiosis based upon evidence presented under one of the prongs, however, "the ALJ must, in every case, review the evidence under each prong of § 921 (c)(3) for which relevant evidence is presented to determine whether complicated pneumoconiosis is present." *Id. See Lester v. Director, OWCP*, 993 F.2d 1143, 1145 (4th Cir. 1993); *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208-09 (4th Cir. 2000)

In the present case, Claimant asserted in closing argument that he wished to invoke the irrebuttable presumption of total disability based upon the existence of complicated pneumoconiosis. (DX 94). Claimant's assertion is grounded upon interpretations by Dr. Siner of two CT scans and x-rays and examinations results obtained by Dr. Emery, a board certified internist specializing in pulmonology. Notably, however, Dr. Emory did not specifically diagnose complicated pneumoconiosis. Further, there is no biopsy evidence in the record. Accordingly, Claimant's evidence in support of his claim of complicated pneumoconiosis is presented pursuant to prongs A and C of § 921 (c)(3). The CT scans fall under prong C as a diagnosis by other means which yields a result equivalent to A or B.

In his interpretations, Dr. Siner referred to the nodule he saw on the CT scan as being 1 cm in diameter. The size of the opacity, as reported, satisfies the criteria for a finding of complicated pneumoconiosis pursuant to prong A. However, his report subsequently classified the nodule as a granuloma, as did Dr. Emery in his reading of a February 25, 1991 x-ray. Granuloma is not included

within the definition of pneumoconiosis as set forth in Section 718.201 of the regulations, and no physician otherwise described granuloma as complicated pneumoconiosis or its diagnostic equivalent. The Fourth Circuit stated that x-rays can lose their probative force if the evidence affirmatively demonstrates that the opacities are either not present or not what they appear to be due to an intervening pathology. *Id*. at 3. In evaluating the evidence pursuant to the standards announced in *Eastern Coal Co.*, the CT scans and the February 1991 x-ray, both of which classify the opacities as granuloma, lose their probative force because the etiology of the nodules is reported to be unrelated to coal mine dust exposure. Furthermore, there is no other evidence on the record which supports a finding of complicated pneumoconiosis. Accordingly, I cannot afford Claimant the benefit of the irrebuttable presumption in accordance to § 718.304.

Without the benefit of the irrebuttable presumption, Claimant must establish total disability due to pneumoconiosis pursuant to the provisions of § 718.204. As previously mentioned herein, the Regulations provide four methods by which to establish total disability. In the present case, none of Claimant's blood gas studies or pulmonary function studies yielded qualifying results. While Dr. Peralta diagnosed cor pulmonale, his opinion is silent as to right sided congestive heart failure. (DX 14). Furthermore, there is no other report by any physician in the record which provides a diagnosis of cor pulmonale. Therefore, in consideration of the all of the evidence in the record, I conclude that Claimant has not demonstrated that he suffers from cor pulmonale within the meaning of Section 718.204(a)(3). Whereas total disability cannot be established under the three prior subsections, § 718.204 (c)(4) is the last remaining method available to Claimant by which to establish total disability. Under §§ 718.204(c)(4), "all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element." *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201, 1-204 (1986).

To accord a medical report full probative value, it must be both well reasoned and well documented. A documented opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Justus v. Director*, OWCP, 6 B.L.R. 1-1127 (1984). Pertaining to the second requirement, a reasoned opinion is one where the judge determines that the underlying documentation and data adequately supports the physician's conclusions. The determination as to whether a medical opinion is both well documented and well reasoned is within the discretion of the Administrative Law Judge. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(*en banc*).

Dr. Odom was the first physician of record to declare Claimant to be totally disabled for coal mine work in a report dated September 20, 1973. (DX13). Dr. Odom provided no rationale or basis for his conclusion that Claimant was totally disabled. In fact, Dr. Odom listed Claimant's pulmonary impairment to be mild in his interpretation of the pulmonary function studies. Thus, his report appears to be internally inconsistent, entitling it to less weight. Furthermore, the Board has held that it is proper

for an ALJ to discount a doctor's report that is significantly earlier than other reports of record. *Cosalter v. Mathies Coal Co.*, 6 BLR 1-1182-1-1183 (Ben. Rev. Bd. 1984). Accordingly, I find no error in assessments rendered by Judges Glennon and Bonfanti concerning assessment that Dr. Odom's report is too remote in time to be relevant.

Dr. Peralta examined Claimant on January 10, 1980. (DX 14). I find no error in Judge Bonfanti's decision to accord less weight to his report. Judge Bonfanti found Dr. Peralta's report flawed in light of the fact it could not be determined whether the limitations listed were merely recitations from Claimant of his condition or the doctor's assessment of Claimant's condition. The Fourth Circuit has held that a judge cannot conclude, without specific evidence in support thereof, that notations in a physician's report of limitations as to walking, climbing, carrying, and lifting, constitute a mere recitation of a miner's subjective complaints as opposed to an assessment of the physician. *Scott v. Mason Coal Co.*, 60 F.3d 1138 (4th Cir. 1995). Even in light of the Fourth Circuit's decision, Dr. Peralta's opinion is never the less entitled to less weight because there is no rationale basis for his opinion. Furthermore, Dr. Peralta was unable to sate with certainty the etiology of Claimant's limitations. Accordingly, his opinion cannot be considered in making a determination as to causation.

Likewise, Dr. Taylor did not provide an opinion as to etiology of Claimant's limitations, and accordingly, his opinion does not address the issue.

Dr. Patel also diagnosed Claimant with a total disabling respiratory impairment. Dr. Patel is Claimant's examining physician, and it is within the Judge's prerogative to assign greater weight to a treating physician's opinion whose diagnosis is based upon extensive medical information gathered over a number of years. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989). However, it is an error to give greater weight to a treating physician's opinion without addressing its flaws which might render his report less probative. *Collins v. J & L Steel (LTV Steel)*, 21 B.L.R. 1-182 (1999). Dr. Patel stated his opinion that Claimant was totally disabled in a letter dated January 16, 1991. (DX 45, CX 3). While he provided no basis for his conclusion, Dr. Patel again addressed the issue of total disability in a report dated April 15, 1991 and stated that his conclusion was based upon Claimant's chest x-rays. He reported that he did not rely on the results yielded by the pulmonary function tests or the blood gas studies. He reported that Claimant's total disability was 50 % attributable to pneumoconiosis and 50% attributable to other disorders.

Dr. Forehand examined Claimant and conducted laboratory tests in March 1991. He diagnosed a respiratory impairment, but stated that it was largely reversible with inhaled bronchodilators. (DX 49). He characterized Claimant's impairment as mild to moderate. Pertaining to etiology, Dr. Forehand attributed occupational dust, "principally from brick, as the major contributing factor in the development of his lung disease." On the basis of his 1991 report, Dr. Forehand's opinion does not establish a totally disabling respiratory or pulmonary impairment. However, Dr. Forehand provided another report following his September 15, 1998 examination of Claimant. In rendering his opinion, Dr. Forehand discussed Claimant's employment, social and medical histories. He reviewed Claimant's symptoms and discussed the results of an x-ray, EKG, and blood gas study conducted as

part of the same examination. He also reviewed pulmonary function studies from 1991. Dr. Forehand concluded that Claimant was indeed totally disabled, but ruled heart disease as the sole contributing factor to his disability. However, Dr. Forehand's conclusion regarding the etiology of Claimant's disability losses probative value in light of the fact that he found no evidence of simple or complicated pneumoconiosis. Naturally, if he did not see evidence of pneumoconiosis, he would not then subsequently rule a disease he does not believe to be present as a cause of Claimant's disability.

Judge Bonfanti found, in accordance the Fourth Circuit's analysis of the medical opinions, that the reports rendered by Drs. Abernathy and Spagnolo established a totally disabling respiratory impairment. However, both physicians attributed any disability to Claimant's heart disease. I agree with Judge Bonfanti that both "physicians supported their findings with objective results in laboratory studies, as well as, in Dr. Abernathy's report, his examination findings." (DX 64). Dr. Abernathy did not take into account the possibility that

Claimant suffered from pneumoconiosis, as he found no evidence of the disease. According, he opinion regarding causation shall be credited with less probative value. (DX 38).

In Dr. Spagnolo's 1991 report, he discounted the notion that Claimant was suffering from pneumoconiosis. (DX 49). However, he added that even if it could be concluded that pneumoconiosis is present, there is not evidence it resulted in or was related to Claimant's disability. He concluded that Claimant's shortness in breath was caused by his heart disease and not pneumoconiosis.

In short, the two most pertinent opinions regarding causation were rendered by Drs. Patel and Spagnolo. Dr. Patel's most recent report was premised upon his interpretations of several x-rays. He cited no other clinical evidence to support his findings. For all the foregoing reasons, I find that Dr. Patel's report is not well-reasoned and is not sufficient to establish a change in condition in respect to etiology of Claimant's impairment. In contrast, Dr. Spagnolo considered other medical evidence on the record when making his determinations. He reviewed past x-rays, blood gas and pulmonary function studies, and medical reports rendered by other physicians of record in evaluating Claimant's condition. He took into consideration Claimant's social and medical histories as well. I find his opinion better supported by the objective medical evidence on record. Additionally, his credentials as a pulmonary specialist entitle his decision to greater weight.

Therefore, based on all the evidence as a whole, since Claimant has failed to demonstrate that he is totally disabled due to pneumoconiosis, he has failed to establish either a change in condition or, as discussed above, any material mistake in fact. Accordingly:

ORDER

IT IS ORDERED that the Petition for Modification be, and it hereby is, DENIED.

STUART A. LEVIN
Administrative Law Judge